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Rep. Gloria Goeglein
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David Giles
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Stephen Spindler
Judith Tilton



INDIANA COMMISSION ON MENTAL HEALTH

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Authority: P.L. 37-1998

MEETING MINUTES¹

Meeting Date: October 16, 2000
Meeting Time: 9:30 A.M.
Meeting Place: State House, 200 W. Washington
St., Room 233
Meeting City: Indianapolis, Indiana
Meeting Number: 5

Members Present: Rep. Susan Crosby, Chairperson; Rep. Gloria Goeglein; Sen. Steven Johnson; Robert Bonner; David Giles; Galen Goode; Gloria Kardee; Jerri Lerch; Amelia Cook Lurvey; Janet Marich.

Members Absent: Sen. Cleo Washington; Judith Tilton; Stephen Spindler; John Huber.

Representative Crosby called the Indiana Commission on Mental Health (Commission) to order at 9:45 a.m.

¹ Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is <http://www.ai.org/legislative/>. No fee is charged for viewing, downloading, or printing minutes from the Internet.

Gary Bond, Professor, Indiana University-Purdue University at Indianapolis (IUPUI)

Mr. Bond addressed the Commission concerning the Assertive Community Treatment Model. The Assertive Community Treatment Model (Model) is a very intensive case management approach for people with a severe mental illness. The Model was developed in Madison, Wisconsin in the 1970's for high risk individuals (e.g. homeless, substance abusers, or in the criminal justice system) with a severe mental illness. There have been about 25 studies that have examined the implementation of the Assertive Community Treatment Model. The studies have shown the following impacts on mentally ill individuals who were in programs that used the Model:

- Long-term and short-term hospital costs were reduced.
- They demonstrated an ability to live independently and maintain housing.
- Their mental illness symptoms were more controlled.
- A higher quality of life was experienced by both the individual and their family.

The intensive case management (e.g. home visits, housing, medication management) requires one staff worker per ten patients. The high staffing level makes the start-up cost high, but when all the costs and savings are factored together the Model is cost effective. Studies using the Model in Indiana show results that are similar to national findings. Nationally, there are about 340 assertive community treatment programs in operation. In the Midwest, the State of Michigan has been the leader in implementing the Model. The National Alliance for the Mentally Ill (NAMI) has made increasing the number of assertive community treatment programs one of their goals.

Peg Larsen, Court Liaison, Park Center

Ms. Larsen stated that she is on an ACT Team (Assertive Community Treatment Team) in Ft. Wayne. The ACT Team program is very staff intensive and the members of the team are very knowledgeable. Though the ACT Team has been successful, it has been extremely under-funded. The ACT Team has been operating over-budget, but it does not have a nurse on the team because there is not enough money to hire a nurse. Because of the lack of funds they have not been able to hire, train, and retain quality staff.

Concerning civil commitments, Ms. Larsen stated that commitments are an unfortunate necessity. It is always difficult to make someone do something that they do not wish to do. She stated that there is a problem with the temporary commitment statute (IC 12-26-6). She stated that the petition for commitment must include a report by the community mental health center. However, the statute does not address how to determine which community mental health center is responsible for preparing this report. Since it is usually difficult for patients who face civil commitment, community mental health centers are not coming forward to prepare the reports on these patients. Also, dually diagnosed patients are supposed to have reports issued by the Bureau of Developmental Disability Services, but this is not always done. She would like a law that would require the Bureau to be present at a civil commitment hearing and give the court a detailed report.

Ms. Larsen commented that there is not a provider that is clearly responsible for patients who have a dual diagnosis. These people are placed in inappropriate, high cost facilities, and usually have to wait for months to receive proper treatment. While the counties wait for the state to provide a bed at a state operated facility the counties are required to pay for the high costs associated with the wait. Ms. Larsen also noted that there is an inequity

in the state funding. The Division of Disability, Aging and Rehabilitative Services has about 177,000 clients and a budget of about \$500 million. However, the Division of Mental Health serves over twice as many people but receives only about \$300 million.

Amy Biggerstaff, Parent, Indiana Apple Seed Center

Ms. Biggerstaff told the Commission about her experiences with her child. Ms. Biggerstaff adopted a child who was two months old at the time of the adoption. At nine months old he gave up taking naps. He was enrolled in a daycare program but was removed from the program because of his rage against other children. It was difficult to find a psychologist who was willing to treat such a young child. When the child began to hide knives he was placed on the drug Ritalin. When her boy was three years of age the psychologist wanted him institutionalized. The Biggerstaff's refused to place him in an institution. She now takes her son to a psychologist in Chicago because of the difficulty of finding a child psychologist who accepts Medicaid as payment. Her son is now nine years old, 110 pounds, and has been diagnosed with bipolar disorder. He has cut himself, ingested rat poison, bitten others severely, and been suspended from school frequently. The only facility that takes children that is located in the area where she lives does not take Medicaid patients. She has been told that to receive care for her son she must relinquish custody to the state and lose any input into his future care. She knows that children who have autism can receive a Medicaid waiver but Indiana does not offer its severely mentally ill children a Medicaid waiver.

"Chic" S.R. Born, President, Indiana Apple Seed Center

Mr. Born explained that the Indiana Apple Seed Center is an organization that seeks equal justice for all persons. The parent-child relationship is one of the core values in this country. Indiana families who exhaust their mental health benefits are in crisis because the Division of Family and Children has forced families to relinquish custody of their children to receive mental health services. The current state system distorts the value that we place on the parent-child relationship. This system puts parents who are seeking help for their mentally ill children in a terrible position. The Bazelon Center for Mental Health Law reports that the State of Indiana has one of the nation's highest rates of requiring custody relinquishment. Parents who try to help their children by asking the state for assistance are being told that to receive care they must give up their children and not have any future say in their child's care. Other states who have had this problem have adopted legislation to stop custody relinquishment in these cases, Mr. Born asked that the Commission examine this problem and provide a solution.

Cary Miaman, Parent, National Alliance for the Mentally Ill (NAMI)

Ms. Miaman is the parent of five boys, one of whom has autism and one of whom has a mental illness. Their family life is not normal. They are not able to take vacations or spend time with other families. Though the family's medical expenses are increasing, she has had to quit work because of her son with a mental illness. He rages at the smallest thing and at age eight he tried to hang himself. He is only able to attend school for two hours a day. The newest class of mental health drugs has helped him. Indiana does not really have health insurance parity for mental illness as demonstrated by the fact that her son is

limited to ten visits for his mental illness per year. Ms. Miaman stated that her autistic son is on a Medicaid waiver waiting list, but there is no list for her more severely mentally ill son to be placed on. She is eligible to receive respite care for her autistic child but not for her mentally ill child. She would like her mentally ill child to receive the care that he needs so that later in life he can support himself.

Barbara Collins, Grandmother, NAMI

Ms. Collins is the grandmother of a five year old boy (Brandon) with a mental disorder. He has been hospitalized four times since last February. She looked for a placement diversion program (i.e. a program where the child lives at home and receives day treatment) in the region surrounding her home. There are no placement diversion programs for young children in Lake, LaPorte, or Porter counties. She was told that her grandson needed residential treatment care and that her only option to receive this care was to have Brandon declared to be a child in need of services (CHINS). The only residential facility in Indiana that treats children is located near Indianapolis and that facility only treats teenagers. Brandon ended up being sent to a 30 bed facility in Milwaukee, Wisconsin. All 30 children at this facility are from Indiana. She and other parents in the state are asking that a residential facility for children under six years old who have a mental, emotional, or behavioral disorder be established in Indiana. She presented the Chairperson a petition with over 2,000 signatures asking for the establishment of placement diversion programs for children under six years of age, residential treatment centers for young children, and an end to the practice of requiring that the parents' relinquish custody of their child in order for the child to receive treatment.

Dr. Ted Petti, Chairman, Mental Health Association in Indiana

Dr. Petti distributed his remarks to the Commission (Exhibit #1). His comments included the following points:

- Indiana has a poor record of early identification of young children and adolescents who are at great risk of developing a severe psychiatric disorder.
- Programs such as the Dawn Project and the Kids Cope program that place a premium upon having the family learn to become more self-sustaining in managing their burdens need to be expanded to other communities.
- Funds need to be decategorized so that agencies can blend funds together to create a productive mix of services.

Dr. Petti proposed that \$1,170,000 be appropriated to start five new programs similar to the Dawn Project and that these and existing projects be studied to find the most effective and efficient means to provide care to emotionally disturbed youngsters.

William Glick, Executive Director, Juvenile Justice Task Force

Mr. Glick stated that there are many children with a mental illness, suffering from substance abuse, or in special education programs that are in the juvenile justice system.

However, the exact number of these children in the juvenile justice system is not known because the data is not collected. Many of the children in the juvenile justice system would not be there if early intervention had been available to them. Money is not available to pay for the mental health assessment of juvenile detainees. Indiana has 25 juvenile detention centers that serve the 92 counties. Some detention centers have mental health counselors, but most do not. Only one detention center has a working agreement with a local community mental health center. Students who are eligible for special education services are entitled to those services even if they are in a detention center. However, most juveniles are not assessed to see if they qualify for those services. Mr. Glick has worked on an assessment tool, called Personality Inventory for Youth (PIY), that he hopes will help with this problem. The PIY is a low cost assessment tool that is easy to administer and is written at a grade school level.

Kim Walton, Director of Youth Services, Gallahue Mental Health Services, Community Hospitals Indianapolis

Ms. Walton distributed an outline of her remarks (Exhibit #2). She stated that three years ago only one mental health therapist served the entire Indianapolis Public School (IPS) system. The past few years have seen the partnership with IPS and other schools grow. There are several advantages to providing mental health services in a school (e.g. increased accessibility, no stigma of getting care at school as opposed to a mental health center). Services that are provided at the schools include: assessment; crisis intervention; individual therapy; group therapy; family therapy; case management; consultation; and day treatment. Most services have been paid by Medicaid. Students who need mental health treatment, but do not have Medicaid or private insurance, receive treatment. Several agencies are collaborating together to provide mental health services to children in the schools. Expansion to other schools is slow because of the start-up costs and expenses that are experienced in the first three months of operation.

Marge Towell, Executive Director, Marion County Mental Health Association

Ms. Towell stated that she has been involved in two very successful collaboration projects: the Dawn Project; and the Integrated Youth Services Program. The Integrated Youth Services (IYS) Program is located within the Lawrence Township school system. The IYS Program is in its second year of operation. The Program identifies at-risk children and children in need of mental health services at the 1st and 2nd grade level. The IYS Program then helps teachers learn to work with these children to enable the children to be successful in the classroom. Collaborative efforts are generally inexpensive. Much of the progress made in schools comes from the attitudes and approaches toward mentally ill children that are changed. The Surgeon General's report on mental health has called for more collaborative efforts to reach children. Ms. Towell concluded by asking the Commission to form a task force to make an in-depth study of school-based mental health collaborative options.

Knute Rotto, Executive Director, Indiana Behavioral Health Choices, Inc.

Mr. Rotto distributed the Dawn Project's three year report to Commission members (Exhibit #3). The Dawn Project was started in 1997 with a \$75,000 planning grant. Each

year the Dawn Project has combined about \$8 million from several different agencies to create plans that are tailored to each child in the program. Existing money that would be available to the child is combined to be used in the child's unique plan. He stated that one out of every five children has either a mental illness or an emotional or behavioral problem. The Dawn Project has served about 350 children in the past three years. 70% of these children have had special education needs, 65% were eligible for Medicaid, and 100% were already involved in more than one public program. Planning is under way to start similar programs in four other communities in the state.

Wanda K. Mohr, Ph.D., R.N., F.A.A.N., Indiana University-Purdue University at Indianapolis (IUPUI)

Ms. Mohr stated that she is an academic and researcher who has many years of experience working with and studying children with mental health problems. The U.S. Surgeon General issued a report on the state of children's mental health that estimated more than 7 out of 10 American children are not receiving mental health care. Nearly 60% of adolescents who are identified by their doctor as needing mental health services never receive them. The problem is worse for minority children and children without health insurance. Surgeon General David Satcher stated in an interview that public schools should be used to identify and treat children with mental health problems. Early intervention to address mental health problems is needed for long-term success. Ms. Mohr cited various benefits of having mental health services located in schools (Exhibit #4). Ms. Mohr concluded by asking the Commission to establish a task force to examine the issue of collaborative school-based mental health services.

Robert Marra, Director, Division of Special Education, State Department of Education

Mr. Marra distributed to the Commission copies of Meeting the Challenge: Alternative/Residential Services, 1998-99² (Exhibit #5). In the 1980's a special account was created to send children out-of-state to receive care for their disabilities. The law was later amended so that money in the account could be used for in-state care. The philosophy of care has changed over the years so that now children are treated in the most natural environment possible. The Division of Special Education still places about 55-65 children out-of-state each year. Parents have never cared about the label that is placed on their child's disorder, they want help and treatment for the problem. Children do not need new programs - they need the services that will assist them in their personal situation. Governmental agencies tend to try to move children to a different agency so the services and treatment are funded out of the other agency's budget. Because there is not enough money in the mental health/special education system it is important that the money be used for the services the children really need. Mr. Marra stated that even though he has expertise in special education he has difficulty navigating through the current system. He does not know how a family seeking services for their child is expected to work their way through this difficult system and receive the treatment they need. Since most children are in school already, schools can play a big role in providing mental health and special education services.

² Final report to the Indiana Department of Education, Division of Special Education, prepared by the Indiana Education Policy Center, Indiana University, September 1999.

Julie Maxwell Berry, Parent/Teacher

Ms. Berry explained the difficulties that parents of mentally ill children face when dealing with psychiatrists, counselors, school administrators, and judges. Her son has attempted suicide on several occasions. He has been placed on nine different psychiatric medications in hopes that one could be found that would help. Ms. Berry and her husband describe themselves as middle class, college educated individuals who have a stable home. However, trying to get help for their son left them exhausted, discouraged, overwhelmed, and financially depleted. The Dawn Project offered them an opportunity to help their son and family build on the strengths that were already present and fill the existing needs. The first time that anyone had asked the family what it was that they needed was in the Dawn Project. Her son's life has changed for the better since being in the Dawn Project. Ms. Berry distributed her comments to the Commission (Exhibit #6).

Karen Sharp, Attorney

Ms. Sharp stated that she was speaking on behalf of Dr. Carol Farral from Indianapolis. Washington Township schools are part of the Dawn Project. Teams are formed that meet monthly to coordinate services for the children being served. She believes that the Dawn Project concept needs to be expanded beyond Marion County. To create a successful program the following principles need to be built into the program:

- The program must build upon the family's natural supports in the community.
- Services and treatment must be individualized to each family.
- The treatment plan must be flexible to changing needs.
- Services and treatment must be provided in a timely fashion.

Cynthia D. Jackson, Ed.D., Behavioral Specialist, Education/Student Services Department, Indianapolis Public Schools

Dr. Jackson presented a brief description of several different students and their behavioral and mental health situations (Exhibit #7). She stated that research and practice have provided the following information concerning children with emotional needs who require special services:

- Socio-environmental factors impact and influence behavior and emotional development.
- Early intervention is necessary to provide lasting change. If antisocial behavior is not changed by 3rd grade the child cannot be cured but must be managed with continuing intervention for what has become a chronic condition.
- Providing services to at-risk students, instead of waiting for a serious level of need to develop, increases the mental health system's ability to respond to emergency situations.
- Distressed families are helped best by agencies that work together and address the needs of the family, not the label or diagnosis placed on the

child.

Dr. Jackson concluded by stating that many plans have been developed in the past that were not implemented³. She called upon the Commission to help Indiana respond to the issues facing the thousands of mentally ill children in the state.

Betty Bledsoe, Parent/President, Families Reaching for Rainbows

Ms. Bledsoe explained that she has been a foster parent to children with disabilities for 15 years. She distributed a letter that summarized her situation with her adopted daughter and experiences in the Dawn Project (Exhibit #8). Ms. Bledsoe's 10 year old daughter came to their family as a foster child. When she was a foster child they struggled as foster parents who did not have rights and they had difficulties getting services. When their foster daughter was six years old she had three psychiatric hospitalizations during a three month period. The Office of Family and Children proposed placing their foster daughter in an institution or moving her to another placement. The Bledsoe's just wanted her to get assistance without going bankrupt. In May of 1997, they were accepted into the Dawn Project and with the Dawn Project's help their daughter improved. In July 1999, the Bledsoe's adopted their foster daughter and as a result they were told that their daughter no longer qualified for the Dawn Project. Since then her condition has deteriorated. She is currently in the Methodist Psychiatric Unit for Adolescents. Her daughter is currently on four different waiting lists to get help. Waiting lists do not help anyone. She concluded by asking the Commission to help provide strength based teams, like the Dawn Project, for each child and family that needs assistance.

Judith Turpin, Parent, Anderson, Indiana

Ms. Turpin distributed a letter concerning her experiences (Exhibit # 9). Ms. Turpin is the parent of two adult children who experienced mental health needs as young children. She is the founder of Indiana Federation of Families for Children's Mental Health. She has pleaded for more accessible, affordable, family-friendly services. The State offered to place her children in out-of-state institutions at a cost of about \$240,000 a year. She kept them at home while earning \$20,000 a year. She provided many of their mental health care services out of her own pocket. Eventually she went bankrupt. Though she favors treating the mentally ill in the least restrictive environment, many times this translates into providing less services until the person fails and enters a crisis situation. She stated that Indiana's mental health insurance parity law is good. However, health insurance companies have violated the intent of the law by placing unrealistic caps on the number of days of mental health treatment and restricted access to psychiatric medicines.

Representative Crosby adjourned the meeting at 2:30 p.m.

³ E.g. A Plan for a System of Services for Indiana's Seriously Emotionally Disturbed Children and Adolescents (1989)